Principles of Biomedical Ethics

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Shahid Athar, MD, FACP, FACE

Department of Endocrinology and Medicine
St. Vincent Hospital and
Indiana Unversity School of Medicine
Indianapolis, Indiana

Abstract:

In this presentation, I will discuss the principles of biomedical and Islamic medical ethics and an interfaith perspective on end-of-life issues. I will also discuss three cases to exemplify some of the conflicts in ethical decision-making.

Key words: Islamic medical ethics, end of life, interfaith.

The following is a discussion of the principles of biomedical and Islamic medical ethics, the position of the Islamic Medical Association of North America (IMANA) on end-of-life issues, and an interfaith perspective on end-of-life issues. I will discuss the questions that are sent to me via email after I give talks all around the country. These queries address when to stop medical care, what the level of life support should be for patients on dialysis, chemotherapy, and ventilators; the question of quality of life, withholding tube feeding or intravenous alimentation or both, and palliative care in the terminally ill, etc.

I will start with my definition of medical ethics. It is a decision-making process involving choosing between more than one option. The options are not all black or all white, or all right or all wrong, but mostly fall into gray areas. In these cases the decision will be choosing a better option over a less desirable one. The difference between what can be done and what should be done is another reason for medical ethics. For example, a woman can have an embryo implanted in her uterus that has resulted from the union of her son-in-law's sperm and her daughter's ovum. Is the woman the mother or grandmother of the baby when it is born? Even though it can be done, should it be done?

These are examples of the questions we face in medical ethics. This symposium is related to end-of-life issues. Those who work in intensive care units (ICUs) or hospitals see these situations all the time. Some examples follow.

An elderly person is on a ventilator and is attached to multiple tubes. The family is present, but because there is not a living will, they do not know what to do. They do not know whether their loved one is alive or dead. The monitor says he is alive, and the urine bag is full, but how long will this continue? Terri Schaivo was on tube feeding for 15 years, and the cost of her care was at least a million dollars. How long should she have been kept in that situation? Is it a question of compassion, or is it a question of care? Are patients in such situations dead or alive?

Are ethics and morality the same thing? Everyone has some moral values, but do they have ethics? What about medical ethics? Are religious, medical, and secular ethics the same? Those who do not believe in a deity, or at least say that they do not believe in God, do they have ethics and morality? How do we care for those people? How do we take their views into account? If the patient is unable to speak for himself, who guards his interests? Is it the family, the physician, or the state? If a patient does not have a living will, does his body become property of the state? The state can intervene, as it did in Terri Schaivo's case. If the doctor withdraws the tube on his own, can he be charged with murder? When the family members' and the caregivers' views clash, whose view do we accept? Is the doctor playing God? If two members of the family have conflicting opinions, what should we do? These matters need to be evaluated and solved ahead of time.

We had a case some time ago involving a man who reverted from Jehovah Witness to mainstream Christianity without his family's knowledge. He was in an automobile accident and was bleeding. Based on his family's belief about his faith, they refused a blood transfusion for him. The man's friend, who happened to be a Muslim, was aware of his conversion and he was called to the medical ethics meeting held to determine whether to give blood or follow the family's wishes based on the belief that their son

Correspondence should be directed to

Shahid Athar, MD, FACP, FACE
sathar3624@aol.com

was a Jehovah Witness.

In Middle Eastern cultures it is acceptable to keep the news of a cancer diagnosis from a patient. After time, the patient will find out. Is it better to hear the diagnosis from the physician or a third party, such as a family member who knows about the diagnosis?

Ethical terms are listed below for those who are not familiar with bioethics.

Autonomy: People are autonomous in their decision-making if they are able to understand the options and decide on a path voluntarily. This principle requires informed shared consent. The patient and doctor should take time to consider consequences of refusal or acceptance of the test and of the treatment or the procedure being proposed.

Beneficence: The principle of beneficence requires positive action, doing something good, preventing what is bad, and preventing what is harmful. In other words, beneficence removes what is bad, what is harmful, and promotes what is good and beneficial. This is positive in that it benefits the patient.

Nonmalficence: The principle of nonmalficence requires a person to refrain from harming others by acts of cruelty and torture. When I was in Turkey, we talked about the position of the Islamic Medical Association of North America (IMANA) on the issue of torture, which includes any cruel action. The Islamic Society of North America (ISNA) and IMANA have participated in the National Society Against Torture. These are principles of nonintervention. Nonmalficence requires that a person exercise due care so as not to unintentionally harm others through their actions. Sometimes we do procedures and tests or give medications without thinking about the possible harm to the patient. Nonmalficence includes anything that may harm the patient, for example giving morphine with the intention of relieving pain even though it can cause respiratory failure. You must explain to the patient how morphine, in this case, may harm them. Nonmamalficence also includes acts such as reckless driving.

Distributive Justice: This principle requires a fair distribution of benefits and burdens. It requires that the person receive what he deserves and his due human share. This principle is involved in decisions to allocate scarce health-care resources, such as the use of intensive care beds and ventilators, in the case of a pandemic. Hospitals and mosques are not prepared to answer this question; therefore, how would the resources be distributed if there is a problem? We need to think about it and need to work to achieve that.

Islamic Medical Ethics: The principles of Islamic medical ethics are twofold. 'Whoever saves a human life has saved the life of the whole mankind." There is then strong emphasis on saving life. The second principle sets an emphasis on seeking a cure. Particular *ahadith* require the Muslim student, resident, or physician to seek a cure for diseases and do research. What is incurable now may not be incurable 50 or 100 years from now.

Dr. Badawi explained certain Islamic terms previously. *Ijmā`* means consensus, *qiyās* means analogy, and *ḍarūra* means necessity. A guiding principle in Islamic medical ethics is that necessity overrides prohibitions. Taking a life is prohibited but is permissible if one has to abort a fetus to save the life of a mother. For example, it is permissible to perform an abortion on a woman who is suffering from certain cardiac diseases if the cardiologist determined that the progression of pregnancy could result in her death.[1,2]

According to a *hadith*, every human is born with *fiṭra*, which is good human nature. As Muslims we take care of each other before asking whether the person in need is a Muslim or a Christian. I never ask my patients about their faith unless they bring it up.

Istiḥsān is the juristic preference between two or more values. Sometimes there are two valid arguments coming from different schools of thought. You have to see which is most applicable at the time.

Maṣlaḥa is what is good for the public. If the mosque has only $1,000 in its *zakāt* (poor's due) fund, should it invest in one person or distribute it to several needy school children in the mosque? What is the public good? The good of the public overrides the needs of the individual. The public good is decided after reasoning.

One has to use his innate *fiṭra* and may have to consult with scholars before making a decision. One has to consult the *Sunnah*, which is the tradition of Prophet Muhammed ﷺ; his actions, sayings and acquiescence to actions of his companions. The sources of the *Shariah* (Islamic jurisprudence) are the Qur'an and *Sunnah*. Therefore, I request that

Muslims and sometimes non-Muslim scholars consult the Qur'an and *Sunnah* before they give their opinion on any matter. We should not give our own opinion without first considering what Allah ﷻ and Prophet Muhammad ﷺ have decided on the subject in question.

Is there any place for *ijtihād* or reasoning? Yes. There is a classic *hadith* in which Mu`ādh ibn Jabal, before being sent to Yemen to be a judge, was asked by the Prophet ﷺ on what basis he would judge cases. Mu`ādh replied, "the Qur'an." Then the Prophet ﷺ asked what he would do if he could not find the answer in the Qur'an. The Prophet ﷺ knew that some answers were not present in the Qur'an. For us to say that the Qur'an has answers to everything is not appropriate. Mu`ādh answered he would consult the *Sunnah* of the Prophet ﷺ. The Prophet ﷺ then asked what he would do if he could not find the answer there either. Mu`ādh then said he would make every attempt with his own opinion to make a right decision and that his opinion did come after consulting the Qur'an and *Sunnah*. The Prophet ﷺ was delighted and said, "Praise be to Allah, who has guided the envoy of the Messenger." Therefore, there is a role of *ijtihād* in ethical questions such as transplantation and intubation, to which there is no direct reference in the Qur'an or *Sunnah*.

The goals of Islamic *Shariah* are the protection and preservation of religion and life, protection and preservation of the mind, preservation of property, and progeny. These are the five goals or purposes of Islamic *Shariah*. The general principles of medical bioethics are compatible with the goals of *Shariah*.

One of the rules of Islamic medical ethics is that necessity overrides the prohibitions. One example is an abortion in the patient with a significant cardiac disease mentioned previously. Another example is the prohibition of eating pork. If pork is the only food available and it is probable that one would die of starvation, then refusal to eat the pork would be suicide by starvation. Suicide is also prohibited, even more so, and therefore you must save your life by eating pork if it is the only thing available.

Another rule is choosing the lesser of two harms. Anesthesia is given before an operation, even though it is possible that the patient may not wake up

The public interest overrides individual interest, and harm has to be removed. There is no mention of smoking in the Qur'an or *aḥādīth*, but we know that smoking causes harm. The harm should be removed by prohibition of smoking, especially in public places.

Other rules prohibit harm and harassment, point out that hardship necessitates relief, and delineate that actions are judged based on intention. The latter is a *ḥadīth*.

Local customs are very important. Knowing the culture that is prevalent in that society as well as the opinion of previous scholars is critical when deriving a new judgment (*ijtihād*).

Interfaith and End-of-Life Issues

Most religions believe in an afterlife and uphold the sanctity of human life as well as the dignity of the dying person. Diversity dictates that we share and not impose our values on others. When we started Interfaith Alliance of Indiana in 1984 our job was not to tout that our product was good and another's was not; or that one person would go to hell and another to heaven. Our purpose was to share each others' joy and sorrow. We, as Muslims, have a tendency to talk about our own product all the time. We do not visit churches or synagogues, and that is not right. As much as Muslims like non-Muslims to visit us and learn about Islam we should also try to learn the culture and values of the others.

There is a large percentage of Buddhists in Japan, in Southeast Asia, China, and Thailand. What do they believe in? Death is an integral part of the belief of incarnation, and it is an experience that everyone will go through many times. Brain death is not accepted by Buddhists, especially Japanese Buddhists. They believe that nutrition and hydration should be continued in persistent vegetative state. Euthanasia is rejected by most Buddhists. Withdrawal of intervention when the end is near is not considered immoral by Buddhists. It will be difficult to communicate effectively with a Buddhist about end-of-life needs if you do not know what their values are and what they believe in. My purpose for learning these things is so I can communicate better with my patients and so that my patient will trust me because I care for him and his values. When I give a recommendation, he will be able to understand it better; his compliance will improve.

In Hinduism, life is a transition between a previous one and a next one. Our body is a container for the soul for this life on this earth. My life will contin-

ue even after me. Karma explains that suffering in this life affects the next life.

We talked about a good death and were asked, "What is a good death?" I gave my own opinion, which is something that you may not like. A good death is right on time, in the right place, in a state of right mind. It is a good death when you die in peace, with no financial or other worries, when someone will take care of your spouse and children. The family has a sacred duty to help the dying both before and after death.

Catholics have a value system quite similar to Muslims except for some theological disputes. What about seculars? Twenty percent of Americans say that they are secular, and we need to care for them, we need to know them too. We hope that one day they will change their mind. They regard God as a human creation. They believe that this life is all there is, and that death is the end of life. We disagree on that but we need to keep the differences in religious beliefs out of the health care and hospital environment. Care should be directed toward the need of the individual. Ignoring needs is a form of discrimination. Finally we will discuss some cases.

Case Discussion 1

This is a case Dr. Malika Haque forwarded to me. It was published in the Journal of the American Medical Association (JAMA). A 62-year-old visitor from Lebanon came to the United States for elective surgery. He had a heart attack and coded. He was on mechanical ventilation. The neurologist did not think he would recover, and a son signed a do not resuscitate (DNR) order, but his elder son back home did not agree and wanted his father to receive full care. The patient's wife in Lebanon was not informed of what was happening to her husband. This is a question of values within the family, a question of doctor versus patient.

Dr. Haque's comment: This was a question that was forwarded to me by the American Medical Association (AMA). It was a real case at the Cleveland Clinic, and the AMA wanted to know what needed to be done because it did not know whether to carry out the DNR order on this patient. One son agreed, but the elder son, who was in Lebanon, did not agree, and the mother had not been informed. I thought a great deal about it and I also talked it over with Dr. Athar. We agreed that the mother had to be informed of the seriousness of the situation, and if she did not agree with what the doctors wanted to do then we needed to get help from an imam, who as a religious leader, might be able to convince the family. When the imam was introduced, he convinced the family and the conflict was taken care of. This is a rare situation as usually the physicians are able to convince the family. When the family is not able to be convinced, then other sources need to be consulted. That is where the chaplain, or the imam, depending on the religion of the patient, can be very helpful.

Dr. Badawi's comment: To make this more consultative it is best to have a conference call involving the neurologist, the son, the wife, and an imam. Instead of waiting for a verdict, there would be a process of exchange, which might make people want to implement it rather than being told to do so.

Case Discussion 2

This case was sent to me by Dr. Hasan, who was the chair of IMANA's Board of Regents last year. A 70-year-old woman was diagnosed with poorly differential adenocarcinoma of right lung two years ago. A month later she had appendicitis with a rupture of the appendix that was treated appropriately. She had no chemotherapy or radiation. She had a DNR in the chart. Then she presented with fever, tachycardia, abdominal pain, and significant abdominal distension. She was conscious. Mechanical intestinal obstruction was diagnosed. The surgeon recommended laparotomy. The anesthesiologist said the patient required general anesthesia, intubation, and likely mechanical ventilation. Arrhythmia was possible, and a DNR could not be adhered to, so he would not give her anesthesia. The surgeon said this problem was temporary and could be corrected and therefore the DNR order did not apply in this situation.

How do you respond to this conflict between the surgeon and anesthesiologist? The patient was conscious. She just came with a mechanical intestinal obstruction that happened over the diagnosis of her cancer.

Comment from the audience: If she can herself answer questions, she should be asked. The attending physician would explain that this is how the other physicians are recommending, and the surgery is doable. Most likely she would say yes to the sur-

gery.

Dr. Athar continues: Basically, this case shows that a DNR or an advance directive is not permanent. If there is a change, if something happens, then the physician needs to talk to the patient. "I understand you have a DNR order, but this is something acute that has happened, a certain thing can correct it, do you want to stay in the pain with the abdominal distension and obstruction or do you want it to be relieved?" The physician or surgeon should tell the patient, that her DNR order is not valid at this time, and maybe she should reconsider it.

Case Discussion 3

Another case came from Kaiser Permanente in California. A 25-year-old pregnant immigrant woman who could speak English very well was brought to the emergency room in acute abdominal pain. She was examined in the presence of her husband, and tubal pregnancy was diagnosed. Although she can speak English, her husband answered all the questions for her, and when it came to taking consent before the surgery, he said he would give the consent because he speaks for her. This is a very important part of the culture in some countries, which has nothing to do with Islam. We see this in India, among Hindus as well, that the elder or the man in the family likes to give the final word. It became a dispute because the husband wanted to give the consent, and the physician wanted the patient to sign it herself. It was a question of ethics. Should we disregard the patient's values, whether they are religious or cultural?

I will mention a couple of questions that come to me often: "After a massive brain hemorrhage, my mother was in coma and on artificial life support. Her physician said there is no hope for survival and wanted to stop life support. We love her very much." "As a physician when I find out that a patient has a terminal illness and will die very soon, I tell the truth to them and the family as soon as I know it myself. My patient is from the Middle East where they do not tell the diagnosis. What should I do?" My answer is, "You must tell the truth." I will close by this poem by the late Dr. Hasan Hathout:

> For the wind that blows the sail is the mind,
> but the faith in the heart is a compass to guide,
> what is in eyesight if heart is blind,
> though we all look so good but what is inside,
> who is right who is wrong, only God will decide.

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